

**TRANSMITTAL AND NOTICE OF APPROVAL OF
STATE PLAN MATERIAL**

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER:

0 3 — 0 4

2. STATE:

OKLAHOMA

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL
SECURITY ACT (MEDICAID)TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE

01/01/03

5. TYPE OF PLAN MATERIAL (Check One):

☐ NEW STATE PLAN☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)

6. FEDERAL STATUTE/REGULATION CITATION:

42 CFR 440.120

7. FEDERAL BUDGET IMPACT:

a. FFY 2003 \$ - 956,085

b. FFY 2004 \$ -1,274,781

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Attachment 3.1-A, Page 5a-1.1

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION
OR ATTACHMENT (If Applicable):

Same Page, Revised 04/01/99, TN# 99-04

10. SUBJECT OF AMENDMENT:

Adding non-sedating antihistamines with prior authorizations covered drugs

11. GOVERNOR'S REVIEW (Check One):

☒ GOVERNOR'S OFFICE REPORTED NO COMMENT☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL☐ OTHER, AS SPECIFIED:

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME:

Mike Fogarty

14. TITLE:

Chief Executive Officer

15. DATE SUBMITTED:

March 17, 2003

16. RETURN TO:

Oklahoma Health Care Authority

attn: Billie Wright

4545 N. Lincoln, Suite 124

Oklahoma City, OK 73105

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:

21 MARCH 2003

18. DATE APPROVED:

21 MARCH 2003

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:

1 JANUARY 2003

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:

ANDREW A. FREDRICKSON

22. TITLE:

ASSOCIATE REGIONAL ADMINISTRATOR
DIV OF MEDICAID & CHILDREN'S HEALTH

23. REMARKS:

c: Mike Fogarty
Jim Hancock
Billie Wright

State OKLAHOMA

AMOUNT, DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED
CATEGORICALLY NEEDY

12.a. Prescription drugs (continued)

Cough and Cold Medications: Medications used for the symptomatic relief of coughs and colds will not be a covered drug benefit. Exception: Prior authorization shall be required for non-sedating antihistamines.

Prescription Vitamins and Minerals Products: Legend vitamin medications will not be a covered drug benefit. Exception: Vitamin medications containing fluoride for children and prenatal vitamins shall be a covered drug benefit.

Obesity Medications: Medications with primary usage for the treatment of obesity, such as appetite suppressants, will not be a covered drug benefit.

Less-than-effective Medications: Medications determined by the FDA to be less-than-effective are not covered.

Experimental Medications: Medications that are experimental or whose side effects make usage controversial are not covered.

Legend Medications Requiring Associated Tests: Legend medications requiring associated tests and/or monitoring will be a covered drug benefit only after obtaining prior authorization. A prior authorization process will also be used to authorize coverage of selected non-covered medications for individuals with specific diseases.

Non-Legend Medications: Non-legend medications will not be a covered drug benefit. Exception; Insulin preparations and over the counter contraceptive products shall be a covered drug benefit.

Revised 01-01-03

TN# OK 03-04 Approval Date 5-27-03 Effective Date 1-1-03
Supersedes
TN# OK 99-04

SUPERSEDES TN- 99-04

STATE	<u>Oklahoma</u>	A
DATE RECD	<u>3-21-03</u>	
DATE A	<u>5-27-03</u>	
DATE EFF	<u>1-1-03</u>	
HCFA 179	<u>OK 03-04</u>	